

Indian Point 3
Nuclear Power Plant
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Robert J. Barrett
Site Executive Officer

March 7, 1997
IPN-97-031

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

Subject: Indian Point 3 Nuclear Power Plant
Docket No. 50-286
License No. DPR-64
Reply to Notice of Violation 50-286/96-11-02

Dear Sir:

This letter provides, in Attachment I, the New York Power Authority's response to the subject Notice of Violation. The Authority agrees with the Notice of Violation contained in NRC Region I Inspection Report 50-286/96-11.

The commitments made by the Authority with this letter are contained in Attachment II. If you have any questions, please contact Mr. K. Peters at (914) 736-8029.

Very truly yours,

A handwritten signature in black ink, appearing to read 'Robert J. Barrett'.

FOR Robert J. Barrett
Site Executive Officer
Indian Point 3 Nuclear Power Plant

Attachments

cc: See next page

IF0111

9703170183 970307
PDR ADOCK 05000286
G PDR



cc: Mr. Hubert J. Miller
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U.S. Nuclear Regulatory Commission
Resident Inspectors' Office
Indian Point 3 Nuclear Power Plant

Reply to Notice of Violation 50-286/96-11-02

VIOLATION 96-11-02

During an NRC inspection completed on December 29, 1996 a violation of NRC requirements was identified. The violation is as identified below:

"10 CFR 50, Appendix B, Criterion XVI, requires in part that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to avoid repetition.

Contrary to the above requirements, from August 3 to August 23, 1996, NYPA did not promptly identify that valve PCV-1296 would not perform its safety function. Subsequent valve disassembly on September 12, 1996 confirmed that the valve was not operable.

This is a Severity Level IV violation."

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Response to Violation

The New York Power Authority agrees with this violation. NYPA did not promptly identify that valve SWN-PCV-1296 could not perform its safety function. Subsequent valve disassembly on September 12, 1996 identified limited valve travel such that the valve was not operable.

Reason for Violation

The cause of this violation was the failure to issue a Deviation Event Report when crud was found to be the cause of limited stroke on SWN-PCV-1297. The Deviation Event Report process would have required additional review of the operability of SWN-PCV-1296.

A contributing cause of this violation was the inappropriate continued use of an operability determination for valve SWN-PCV-1296. The operability determination for valve SWN-PCV-1296 was performed to evaluate the stroke capabilities of SWN-PCV-1296 as it related to installation, and not crud behind the valve stem. This operability determination depended upon valve positioner data, and testing performed on the valve in 1992, and not on actual valve stroke measurements. The limitation of this operability determination was not apparent during subsequent evaluations, when crud above the valve plug of SWN-PCV-1297 was discovered to be the cause of SWN-PCV-1297 limited valve stroke.

Radiographic testing performed at the time was inconclusive in regard to crud buildup causing stem restrictions. The radiographic testing was performed to evaluate flow blockage, not crud buildup behind the valve stems. A stroke test was not performed at that time, to avoid risk to plant operations if the service water flow was lost to Control Room Air Conditioning units during the stroke test.

In addition, there were other factors that contributed to the lack of timely identification of valve SWN-PCV-1296 inoperability. A flow path change to the header that supplied service water through SWN-PCV-1297 was required for SWN-PCV-1296 to be repaired or stroked, but was not done due to unusual noises from a service water pump used for that configuration. The responsibility for repair and return of SWN-PCV-1297 to service, modification of SWN-PCV-1296 and closure of associated deviation event reports, was split between several disciplines. This fragmented responsibility resulted in delayed response to the Deviation Event Report associated with valve SWN-PCV-1297, and also caused untimely sharing of information related to the condition of SWN-PCV-1297.

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Corrective Actions Taken

The Authority's problem identification process (DER) is functioning well, and has strong management encouragement for problem identification. The Authority's identification threshold is appropriate, with multiple levels of review.

The procedure used for performing deviation event reports was revised 11/12/96, this revision included enhancements to the operability determination process.

Training was given on this revision to Engineering Support Personnel in the last quarter of 1996.

Corrective Actions to be Taken to Avoid Further Violations

A case study will be developed and added to the 1997 Engineering Support Personnel continuing training program emphasizing the importance of issuing a DER when an additional adverse condition is discovered, ensuring the appropriateness of objective evidence to support the continued use of an operability determination, and the necessity of requesting physical testing of plant components through approved work requests, when appropriate. To be completed by October 14, 1997.

The significance and consequences of this event will be added to the agenda of, and be discussed at, a future tailgate meeting. Special emphasis will be placed on timely and accurate sharing of information between plant departments and the importance of urgency and ownership in responding to plant equipment problems. To be completed by March 27, 1997.

Date When Full Compliance Will Be Achieved

Compliance was achieved on August 23, 1996, in that flow was directed through SWN-PCV-1297 instead of SWN-PCV-1296. Other actions listed should prevent recurrence.

List of Commitments

Number	Commitment	Due
IPN-97-031-01	A case study will be developed and added to the 1997 Engineering Support Personnel continuing training program emphasizing the importance of issuing a DER when an additional adverse condition is discovered, ensuring the appropriateness of objective evidence to support the continued use of an operability determination, and the necessity of requesting physical testing of plant components through approved work requests, when appropriate.	October 14, 1997
IPN-97-031-02	The significance and consequences of this event will be added to the agenda of, and be discussed at, a future tailgate meeting. Special emphasis will be placed on timely and accurate sharing of information between plant departments and the importance of urgency and ownership in responding to plant equipment problems.	March 27, 1997